Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GENESIS OCCUPATIONAL HEALTH
2350 41ST STREET
MOLINE IL 61265

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2094-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The final action on this bill is being DISPUTED. A clean claim was billed to Texas Mutual 4/29/2010. After no response, this was resubmitted on 7/23/2010. I received a denial dated 8/30/2010 for "time limit for filing has expired. " I disupted this decision and submitted a reconsiderations on 9/7/2010. I received another denial of "time limit for filing has expired" dated 9/22/10.

Amount in Dispute: $696.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. Texas Mutual denied this treatment in this dispute due to untimely filing. 2. According to DWC Rule 134.801; Effective 9/1/2005, a health care provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service. Failure to timely submit the medical bill constitutes a forfeiture of the health care provider's right to reimbursement. 3. To be compliant with DWC Rule 134.801; the requestor had from 7/5/10-7/10/10 to file their services with this carrier. Texas Mutual did not receive the complete medical bill from the requestor until 8/3/2010; (exhibit 1) which by that time the filing deadline had lapsed. The requestor does not include any verifiable documentation to support its complete medical bill was timely filed with this insurance carrier…Texas Mutual has no record of receipt of a complete medical bill received prior to on or before the 95th day after the dated of service (which is 7/5/10 – 7/10/10); therefore, it is Texas Mutual's position that the services in dispute were untimely filed."

Response Submitted by: Texas Mutual 6210 E. Hwy 290 Austin TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2010 through April 6, 2010	Professional Services	$696.00	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for health care providers required billing forms/formats.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
4. 28 Texas Administrative Code §102.4 sets out the rules for non-commission Communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 30, 2010 and September 7, 2010
   - CAC-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-W4 NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION
   - CAC-29 THE TIME LIMIT FOR FILING HAS EXPIRED
   - 724 NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
   - 731 PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/2005
   - 873 DWC REQUIRES ALL PHARMACY CHARGES BE SUBMITTED ON THE DWC-66 OR THE ALTERNATIVE FORM, PERDWC RULE 133.10
   - CAC-97 THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWNCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 284 NO ALLOWANCE WAS RECOMMENDED AS THIS PROCEDURE HAS A MEDICARE STATUS OF 'B'(BUNDLED)

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the requestor submit the medical bill for the services in dispute in accordance with 28 Texas Administrative Code §133.20?

Findings

1. The requestor provided services in the state of Illinois on April 1 through April 6, 2010 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was not satisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. Texas Administrative Code §133.20 (j)(1) states "A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: (A) prompt payment, as provided by Labor Code §408.027; (B) interest for delayed payment as provided by Labor Code §413.019; and (C) medical dispute resolution as provided by Labor Code §413.031. Review of documentation submitted by both parties finds two medical bills addressed to employer. The health care provider and requestor in this medical fee dispute has waived there right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.